STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 121486-001**

Humana Insurance Company
Respondent

Issued and entered
this 17TH day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On May 19, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner immediately notified Humana Insurance Company (Humana) of the request and asked for the information it used to make its final adverse determination. The information was provided on May 23, 2011. On May 26, 2011, after a preliminary review of the information received, the Commissioner accepted the request for external review.

The case involves medical issues so the Commissioner assigned the matter to an independent review organization which completed its review and sent its recommendation to the Commissioner on July 15, 2011.

II. FACTUAL BACKGROUND

The Petitioner receives health care benefits as an eligible dependent under an individual insurance policy underwritten by Humana. Her benefits are defined in the HumanaOne certificate of insurance (the certificate).

The Petitioner's coverage with Humana was effective on August 1, 2010. On November 21, 2010, she had a cardiac episode and went to the emergency room for treatment. She followed up with a cardiologist and had a stress test on November 22, 2010, that was abnormal. On November 29, 2010, an angiogram revealed trivial coronary artery disease (CAD).

Humana denied coverage for this care, determining it was for a pre-existing condition and therefore excluded this treatment for the first 12 months following the effective date of the certificate.

The Petitioner appealed the denial through Humana's internal grievance process. Humana maintained its denial and issued its final adverse determination dated April 19, 2011.

III. ISSUE

Was Humana correct when it denied coverage for the Petitioner's treatment in November 2010 because it was for a pre-existing condition?

IV. ANALYSIS

Petitioner's Argument

On her application to Humana in July 2010, the Petitioner acknowledged treatment for hypertension and high cholesterol within the past five years. But she argues that she was being monitored, not treated, for CAD since 1988. The Petitioner states she did not disclose that she had been treated for a cardiac condition in 1988 because it was beyond the five-year look back period specified by Humana. In a March 28, 2011, letter to Humana, the Petitioner explained:

> When we first applied and answered the questions Humana asked on the eligibility and health status number 13 states "Within the past 5 years." I have not seen or been a patient of a Cardiologist since 2002. . . . [M]y primary care physician, is the only medical doctor I have seen as a patient.
>
> As of July 28, 2010, Humana made an amendment to our insurance policy, which we agreed to adding 30% to our premium. The higher rate was due to Hypertension, which your company was made aware of in the first conversation and also on the application. . . . The individual I spoke with for the application was made aware of the 1988 incident which I was told was caused by a birth defect. Nothing was hidden from Humana.
>
> Now as of March 19, 2011, Humana is stating that (The expenses I incurred are not covered as it was related to a pre-existing condition.) Pre-existing condition as explained in your glossary reads "A pre-existing condition is a sickness or bodily injury for which, during the (SIX) month period immediately prior to the covered

> person's effective-date of coverage." I was seeing [a doctor] for Hypertension and Hyperlipidemia. I had not seen any Cardiologist . . . for over eight years, until November 21, 2011.
>
> I . . . believe these expenses should be covered by Humana One. All the proper procedures have been followed.

Respondent's Argument

In its final adverse determination Humana advised:

> We were unable to approve your appeal because it has been determined that your coronary artery disease (CAD) is considered a pre-existing condition. Your policy does not cover any pre-existing conditions for the first 12 months.
>
> The medical records we received . . . indicate that you were seen for CAD on April 22, 2010.
>
> Your policy defines a pre-existing condition as any sickness or illness for which you received medical advice, care or treatment during the five years prior to your effective date that was not fully disclosed on your application. However, the state of Michigan has a mandate that only allows us to look back in the six months prior to your effective date.
>
> When you completed your application you did disclose that you had hypertension. However, you were also asked if you had any other conditions related to the heart or circulatory system that was not disclosed elsewhere and you answered no.
>
> Therefore, because you were seen for CAD during the six months prior to your effective date, and it was not disclosed on your application, it is considered a pre-existing condition. Your policy was effective on August 1, 2010, so the pre-existing condition limitation will expire on July 31, 2011. Until that time, there are no benefits available for any treatment or services related to that condition.

Commissioner's Review

The certificate contains an exclusion for pre-existing conditions (p. 30):

> **6. GENERAL EXCLUSIONS**
>
> * * *
>
> Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:
>
> * * *

8. *Pre-existing conditions* to the extent specified in the *Certificate*; . . .

The Michigan Insurance Code permits a health insurer to include a pre-existing condition limitation in an individual policy or certificate but it must conform to Section 3406f of the Code [1]:

> (1) An insurer may exclude or limit coverage for a condition as follows:
>
> (a) For an individual covered under an individual policy or certificate or any other policy or certificate not covered under subdivision (b) or (c), only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.

Because the pre-existing condition limitation in Humana's certificate differs from this statutory provision in several ways, the Commissioner will rely on the statutory provision to decide this case.

To answer the question of whether the services the Petitioner received in November 2010 were for a condition "for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment" (i.e., between February 1 and July 31, 2010), the Commissioner obtained the recommendation of an independent review organization (IRO) as required by Section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6). The IRO reviewer is a physician who is board certified in internal medicine and has been in active practice for more than 18 years. The IRO report contained the following analysis:

> The MAXIMUS physician consultant noted that the [Petitioner] underwent a cardiac catheterization in November 2010, which demonstrated trivial coronary artery disease. The MAXIMUS physician consultant also noted that the [Petitioner] had been maintained on medical therapy and that according to her medical records, had no complaints of chest pain or shortness of breath. The MAXIMUS physician consultant indicated that the medical record from the [Petitioner's] 4/22/10 office evaluation with her primary care physician noted that she had a diagnosis of coronary artery disease, which was stable on medical therapy. The MAXIMUS physician consultant explained that the medical records demonstrate that [she] received medical advice, consultation, diagnosis care or treatment for the diagnosis of coronary artery disease within the 6 month period prior to her enrollment in the Health Plan on 8/1/10.

1 MCL 500.3406f.

> Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that the services that the [Petitioner] received for the diagnosis of coronary artery disease were for treatment of a pre-existing condition.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded deference by the Commissioner. In a decision to uphold or reverse an adverse determination the Commissioner must cite "the principal reason or reasons why the commissioner did not follow the assigned independent review organization's recommendation," MCL 550.1911(16)(b). The IRO's analysis is based on extensive expertise and professional judgment. The Commissioner can discern no reason why that judgment should be rejected in the present case.

The Commissioner accepts the conclusion of the IRO and finds that the services the Petitioner received on November 21, November 22, and November 29, 2010, were for treatment of a pre-existing condition and are therefore excluded from coverage.

V. ORDER

The Commissioner upholds Humana Insurance Company's adverse determination of April 19, 2011. Humana is not required to cover the Petitioner's treatment received on November 21, November 22, and November 29, 2010.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.